EXHIBIT A

From: Betty LeMaire <blemaire@traceylawfirm.com>
Date: May 14, 2014 at 5:47:20 PM EDT
To: "dthomas@tcspllc.com" <dthomas@tcspllc.com>, Vicki Wolfe <VWolfe@tcspllc.com>
Cc: Clint Casperson <ccasperson@traceylawfirm.com>
Subject: Request for Preservation of Pathology (Patricia Cogzill)

Counsel, attached is a Request for Preservation of Pathology regarding Patricia Cogzill who is scheduled for removal surgery on **6/3/2014**.

Please feel free to contact me with any questions.

Thank you.

Betty LeMaire, Paralegal
Tracey Law Firm
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May 14, 2014

VERY IMPORTANT – REQUEST FOR PRESERVATION OF PATHOLOGY

Via Federal Express
and FAX: 573-499-6095
Attn: Departments of Surgery & Pathology
University of Missouri Women's and Children's Hospital
404 North Keene Street
Columbia, MO 65201

RE: **Revision Surgery Preservation Request & Protocol**
Patient Name: Patricia Cogzill
DOB: 7/4/1944
Date of Surgery: 6/3/2014

Dear Departments of Surgery and Pathology:

I represent the patient, **Patricia Cogzill**. The individuals copied below represent the Defendant, Ethicon Inc. There is no litigation pending against your facility or the treating physician in this matter. I write to request the preservation of pathology material from **Ms. Cogzill's** scheduled for **6/3/014** to be performed by **Dr. James M. Cummings**.

It is important to all parties to this lawsuit that any pathology obtained during this upcoming surgery be preserved for future analysis by the respective experts. The parties request that you preserve, photograph, and divide the specimen(s) obtained as follows:

Instructions for Immediate Preservation of the Specimen(s):

The parties request immediate preservation of the specimen(s) and will separately provide further instructions for preservation of the specimen(s) immediately upon explant.

Instructions for Division into Equal Specimen(s):

The parties request division of each specimen or specimens in equal or nearly equal portions for their respective analysis as follows:

The specimen(s) should be divided such that the amount of foreign material, if any, is approximately equal in the two samples. The division of the specimen(s) into two equal (or nearly equal) portions for the analysis by the Parties shall be as follows:

(a) Cut the specimen(s) (or each piece of the specimen) through the longest axis of the mesh part into two pieces (may or may not be the longest axis of entire tissue
(b) If there is mucosa, the cut needs to be through the point where the mesh is closest to the surface or mucosal defect/ulceration if present;
(c) If there is a nodule, the cut should be through the middle of the nodule; and
(d) Any foreign material and surrounding tissue in the specimen(s) should not be separated prior to dividing the specimen(s) in half.

If in the course of dividing the specimen(s), it becomes impossible to provide two equal (or nearly equal) halves of the specimen(s), please immediately notify the representatives of the parties listed below. The parties will confer re: access to the specimen(s) and provide further instructions re: same.

Instructions for Photographing Specimen(s) Before and After Division:

Additionally, the parties request photographs depicting the specimen(s) before and after division as follows:

Please document the method of division and photograph the specimen(s) prior to and after its division, as follows:

(a) Depicting entire specimen (or specimens, if excised in more than one part) prior to splitting, fresh, without fixative, with scale and identifiers; and
(b) Depicting entire specimen (or specimens, if excised in more than one part) after splitting, fresh, without fixative, with scale and identifiers.

In order to facilitate this request please find a HIPAA-compliant authorization for the release of the specimen(s) to be removed during this surgery, signed by **Ms. Cogzill**. Also enclosed is a chain of custody form. The parties request that this form accompany the specimen(s) when it leaves your facility.

Each party will follow-up separately with further instructions on the mode of preservation and shipping of its half of the specimen(s), and to arrange for reimbursement for any costs incurred by you for preservation, division, and shipping. Should you have any questions or concerns regarding this matter, please contact us by email directed to representatives of all parties: **Clint Casperson** ccasperson@traceylawfirm.com (counsel for Plaintiff), and **David B. Thomas** at dthomas@tcspllc.com (counsel for Defendant Ethicon Inc.).

If you are not the appropriate recipient of this request, please forward a copy of this letter to the appropriate recipient of the request. Please forward a copy of this letter to the appropriate person or entity responsible for ensuring compliance with the terms of this preservation request.

Please contact me with any questions or concerns you may have regarding this matter.

Sincerely,

Clint Casperson,
Counsel for Plaintiff

Enclosures
CC/bl

cc: David B. Thomas
Counsel for Ethicon Inc.
dthomas@tcspllc.com

CHAIN OF CUSTODY FORM FOR PATHOLOGY MATERIALS

[Plaintiff(s) v. American Medical Systems, Inc.]

ENTRY NO. 1

Received by (Name, Company/Organization, Address, and Telephone Number):

____

____

____

Date:

Time:

Signature of Recipient ____

Item Description (include manner of preservation, size of specimen, slide numbers and any other identifying marks):

(1) ____

(2) ____

(3) ____

Note any change of condition:

____

____

Name of Releasing Party

____

____

____

Date:

Time:

Signature of Releasing Party ____

CHAIN OF CUSTODY FORM FOR PATHOLOGY MATERIALS

[Plaintiff(s) v. American Medical Systems, Inc.]

ENTRY NO. 2

Received by (Name, Company/Organization, Address, and Telephone Number):

____

____

____

Date:

Time:

Signature of Recipient____

Item Description (include manner of preservation, size of specimen, slide numbers and any other identifying marks):

(1)____

(2)____

(3)____

Note any change of condition:

____

____

Name of Releasing Party

____

____

____

Date:

Time:

Signature of Releasing Party____

CHAIN OF CUSTODY FORM FOR PATHOLOGY MATERIALS

[Plaintiff(s) v. American Medical Systems, Inc.]

ENTRY NO. 3

Received by (Name, Company/Organization, Address, and Telephone Number):

____

____

____

Date:

Time:

Signature of Recipient____________________________________

Item Description (include manner of preservation, size of specimen, slide numbers and any other identifying marks):

(1) ____

(2) ____

(3) ____

Note any change of condition:

____

____

Name of Releasing Party

____

____

____

____

Date:

Time:

Signature of Releasing Party ____________________________________

MEDICAL AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION

The name or other specific identification of the person[s], or class of persons, authorized to make the requested use or disclosure is:

TO: ______________________________

PATIENT INFORMATION		
Patricia	A	Cozzill
First Name	Middle Initial	Last Name
184 Scenic Shores Lane,	Climax Springs, MO	
Mailing Address – Street	City, State, Zip Code	
	7-4-1944	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
Home Phone	Date of Birth	Social Security Number (SSN#)

I authorize the above-named individual or organization to disclose the above-named patient's health information, as described below, to the following recipients: Tracey Law Firm, 440 Louisiana, Suite 1900, Houston, Texas 77002, TELEPHONE 713/495-2333, FACSIMILE 713/495-2331, or any of its representatives, for the purpose of: "at the request of the individual".

This authorization shall also serve to permit a representative from the Tracey Law Firm, to conduct a personal review of all medical information that you may have pertaining to the patient named above and to orally discuss this information with you.

The type and amount of information to be used or disclosed is as follows: The complete medical record/chart of the above-named patient and all materials or information including, but not limited to, all medical records, hospital records, physicians' records, surgeons' records, consultation records, operative reports, physical therapy and other therapy records; x-ray, CT scan, MRI, PET scan and reports or other diagnostic studies; laboratory reports; patient information and history questionnaire; physicals and history; discharge summary; progress notes; prescriptions and medication records; nurses' notes; psychotherapy notes, correspondence; consent for treatment; statements for services rendered; or any other materials (whether written or stored, created or maintained in any other form) relating or pertaining to this patient, including documents and records received from or that were created by another provider.

I understand that the information in the patient's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, or treatment for alcohol or drug abuse.

This authorization shall remain in full force and effect until it expires three years from the date set forth below. PHOTOCOPIES OF THIS RELEASE ARE VALID.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing by sending or presenting my written revocation to the Privacy Contact of the health care provider named above. I understand that the revocation of this authorization will not apply to the extent that the health care provider has taken action in reliance thereon; or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that authorizing the disclosure of this health care information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure of the patient's health information by the recipient, resulting in the health information no longer being protected by federal or state confidentiality rules.

Signature: *Patricia A. Cozzill*
(Patient and/or Legal Representative)

5-14-2014
Dated: